MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTED HOUSING PROGRAMS

Application For Relicensure

IF APPLYING FOR A LEVEL I, II, III, OR IV RESIDENTIAL CARE FACILITY THE APPLICATION MUST BE ACCOMPANIED WITH A **NON-REFUNDABLE FEE OF $10.00 FOR EACH BED REQUESTED.** IF APPLYING FOR AN ASSISTED LIVING PROGRAM THE APPLICATION MUST BE ACCOMPANIED WITH A **NON-REFUNDABLE FEE OF $200.00. MAKE CHECKS PAYABLE TO: TREASURER, STATE OF MAINE.**

Application for : Level I _____ Level II _____ Level III _____ Level IV _____ Assisted Living: Type I _____

Level I (PNMI) _____ Level II (PNMI) _____ Level III (PNMI) _____ Level IV (PNMI) _____ Type II_____

Note: Adult Family Care Homes are either Level III or Level III PNMI

Name of Facility: _____

Location of Facility (911 Addrress): _____

Mailing Address of Facility: _____

Mailing Address of Agency: _____

E-Mail Address:_____

Name of Administrator:_____

Telephone Number of Facility_____Telephone Number of Agency _____

PLEASE INDICATE WHICH ADDRESS ALL FUTURE CORESPONDENCE SHOULD BE SENT TO:

☐ Agency/Owner Mailing Address ☐ Facility Mailing Address

Current number of licensed beds:_____Increase / Decrease in number:_____

Facilities licensed for 6 beds or less: How many full and part-time employees? (Do not include owners and those employees related to owner) _____

Additions / renovations to facility: _____

_____

Other changes: _____

_____

Does facility have a waiver? Yes _____ No _____ If so, please indicate Item # and reason for waiver

_____

Does waiver still apply? Yes _____ No _____

Have you (Applicant, Administrator and/or member of household) ever:

	YES	NO
Been convicted of a crime?	___	___
Been an inpatient in a mental health facility?	___	___
Been treated for drug/alcohol abuse?	___	___
Been investigated for child/adult abuse, neglect, or exploitation?	___	___
Had a license / application to operate a residential care facility revoked / denied / placed on conditional status?	___	___

If you (Applicant, Administrator and/or member of household) answered "YES" to any of the above questions then please explain and state persons involved.

_____

_____

_____

The applicant certifies that information contained in this reapplication is true and correct to the best of their knowledge. The Department of Health and Human Services reserves the right to determine the suitability of the applicant for relicensure.

I, _____, being duly authorized to assume responsibilities for the conduct of the facility herein described, do hereby apply for relicensure / re-approval to operate the facility and do agree to assume responsibility that the facility will comply with all the current regulations of the Department of Health and Human Services, as authorized by Title 22, M.R.S.A. §7802.

_____ _____
Date Signature of Applicant

_____ _____
Date Signature of Co-Applicant

_____ _____
Date Signature of Owner, if different from above; Corporate officer, if operated by a Corporation

Please return to: Department of Health and Human Services
Division of Licensing and Regulatory Services
Community Services Programs
11 State House Station
Augusta, ME 04333

FOR OFFICE USE ONLY

FEE RECEIVED _____

CHECK # _____